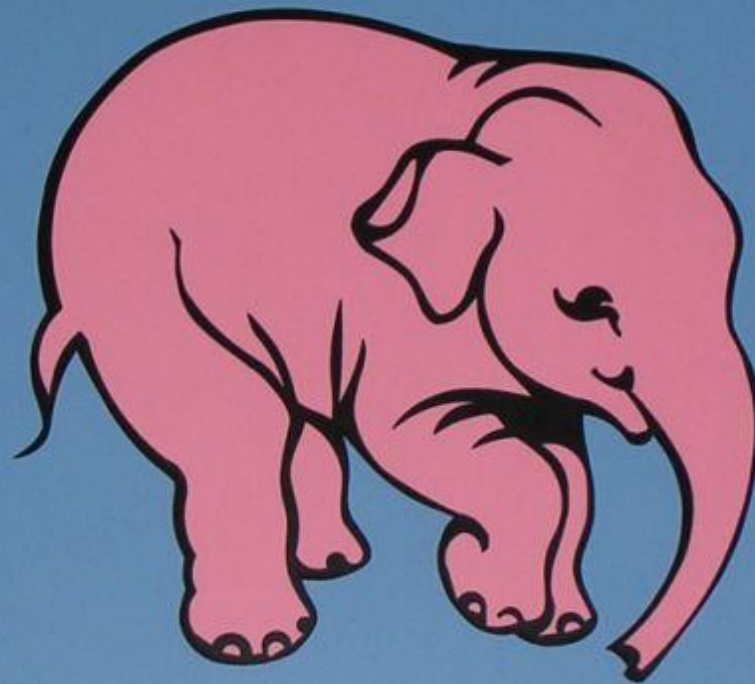


DELIRIUM

PSYCHIATRY'S ROLE IN
DIAGNOSIS, EDUCATION,
AND MANAGEMENT



DELIRIUM tremens



Head, Consultation-Liaison
Psychiatry, St. Paul's
Hospital, Vancouver



Dr. Carole M. Richford

Delirium

- A. Disturbance of consciousness/attention with reduced ability to focus, sustain, or shift attention
- B. **A change in cognition (memory, disorientation, language) or perceptual disturbances**

DSM-IV TR, APA Press, 2000

Delirium

C. Disturbance develops over a short period of time and fluctuates throughout the day

DSM-IV TR, APA Press, 2000

Delirium

- D. There is evidence from the history, physical exam, or laboratory findings that the disturbance is caused by the direct physiologic consequence of a general medical condition**

DSM-IV TR, APA Press, 2000

Hyperactive vs. Hypoactive Delirium

Hyperactive

- Agitated
- Hallucinations
- Restless
- Yelling
- “Code White”
- Requires restraints

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Hypoactive

- * **Flat affect**
- * **Non-responsive**
- * **Quietly paranoid**
- * **Suspicious**
- * **Whispering**
- * **Withdrawn**

Prevalence:

- * Most common clinical syndrome seen by Consulting Psychiatrists in general hospitals

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- * Most common clinical syndrome seen by Consulting Psychiatrists in general hospitals
- * 10-15% of General Surgical pts
- * 15-25% of General Medical pts
- * **30-45% of hospitalized Geriatric pts**

Brown TM, Psychiatric Care of the Medical Patient, 2000

Prevalence:

- * 30% of surgical/cardiac ICU pts
- * 40-50% post-hip replacement
- * 30-40% pts with AIDS
- * In CSICU, average incidence 38.5% with a range of 0-73.5% (based on review of 15 relevant studies)

Dyer CB, Ashton CM, *Postoperative Delirium: A Review of 80 studies*,
Archive of Internal Medicine. 1995; 155.

Pre-surgical Risk Factors:

- * Previous delirium
- * Very young and elderly
- * Depression
- * Substance use – Etoh, MJ, cocaine, nicotine
- * History of stroke, TIA
- * Dementia
- * Visual or hearing impairment
- * Poly-pharmacy – opioids, steroids, metoprolol, benzodiazepines

Neuropathophysiologic Models of Etiology

- * Neuronal dysfunction in the cortex and RAS; with sparing of cerebellum
- * Increasing literature showing excessive dopamine release & slowed reuptake in times of metabolic stress, that is neurotoxic

Brown TM, Psychiatric Care of the Medical Patient, 2000

- * Other mechanisms:

- * Decreased cerebral perfusion
- * Final common pathway involving acetylcholine and dopamine
- * Sleep/wake cycle disruption and speculated role of melatonin

Role of Psychiatry

- * Identify and confirm diagnosis of Delirium
- * Prevent episodes in vulnerable patients
- * Treat symptoms

Role of Psychiatry

- * Manage behaviour
- * Educate patients and families
- * Support staff
- * Ensure safety of patients and staff

Delirium Assessment

- * A&O x3 is not good enough!
- * Use screening tools like CAM, CAM-ICU, ICDSC
- * DSM-IV TR diagnostic criteria
- * Follow severity of delirium with the DRS
- * Follow cognitive status (MMSE, MoCA)

Consequences of Delirium

- * Increased Morbidity
 - * Pneumonia
 - * Decubitus ulcers
 - * Falls
 - * Infected sternum
 - * Prolonged hospitalization
 - * Prolonged recovery

Consequences of Delirium

- * Increased Mortality
 - * Estimated 3 month mortality among hospitalized patients with delirium is 23-33%
 - * 1 year mortality has been reported at 50%

Consequences of Delirium

- * Persistent Cognitive Deficits
 - * Full cognitive recovery in elderly only 4-40% at time of discharge
 - * Delirium may uncover preexisting dementia
 - * Significant sleep/wake disruption

Rockwood K: The occurrence and duration of symptoms in elderly patients with delirium. J Gerontology 1993; 48

Consequences of Delirium

- * Anxiety

- * Insomnia

- * Acute Stress Disorder

- * Post Traumatic Stress Disorder (PTSD)

- * Depression

- * Assumption is depletion of essential neurotransmitters; dopamine, catecholamines

Psychiatric Management

1. Coordinate with other Physicians
2. Identify etiological factors
 - a. Review history, collateral, labs
 - b. Order further investigations
 - c. Liaise with attending team

Management

3. Initiate Psychopharmacological meds
4. Monitor and Ensure Safety
5. Assess and Monitor Psychiatric status

Management

6. Promote environmental and supportive interventions
7. Support and educate patient and family
8. Provide postdelirium management

Environmental Interventions

- * Lighting
- * Stimulation
- * Familiar people/objects
- * Visual &/or Hearing aids
- * Close Nursing
- * Frequent reorientation

Pharmacological Treatment

- * First generation Antipsychotics
- * Second generation Antipsychotics
- * Benzodiazepines (limited use)
- * Cholinergics (poor results)
- * ECT
- * ?Melatonin

Summary

- * Psychiatry has a KEY role in the prevention, diagnosis, and management of delirium
- * Screening tools are needed to standardize assessments
- * RCTs long overdue for antipsychotic treatment in delirium